First Steps Briefing Paper:

Maternity Support Services to High Risk Women

Department of Social and Health Services

and

Department of Health

Washington State

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Program History

The purpose of RCW 74.09.760 thru 910, known as the Maternity Care Access Act of 1989, is to "provide, consistent with appropriated funds, maternity care necessary to ensure healthy birth outcomes for low-income families". Key components of the act included the removal of unnecessary barriers to prenatal care, a single entry point with expedited eligibility determination, access to preventive and other health care services for low-income children and the reduction of unnecessary barriers for health care providers to provide prenatal care.

In the beginning, alternative maternity care service delivery systems were established in geographic regions identified as having inadequate access to care. Statewide Maternity Support Services (MSS) and targeted case management services were established along with expedited access to substance abuse assessment and treatment services, childbirth education and First Steps child care. The premise of the Maternity Care Access Act of 1989 is that preventive care leads to healthier families and the reduction in infant illness and death while containing health care costs. Premature and low birth weight births have been directly linked to infant illness and death.

A timeline that identifies events and issues that have had an impact on the First Steps program, both on providers delivering services and clients receiving services since the enactment of the Maternity Care Access Act of 1989 can be found in Appendix A. The timeline also displays data from the First Steps database showing number of births, % of low birth weight, and entry into first trimester care for specific years.

What are the Problems?

1. Overall, Medicaid women have disproportionately higher rates of poor birth outcomes than Non-Medicaid women. Subgroups within Medicaid women demonstrate the highest rates of maternal risk factors associated with low birth weight (LBW) and the poorest birth outcomes.
2. Since 2003, entry into first trimester prenatal care for Medicaid women has been declining and the disparity in prenatal care access between Medicaid and non-Medicaid women has increased.

1. Poor Birth Outcomes

Medicaid women are divided into 3 categories: Non-Citizens (Medical-only), S Women citizens (Medicaid eligible due to pregnancy) and TANF women (Medicaid eligible prior to pregnancy). The following chart demonstrates that TANF women (or grant recipients) have higher rates of prior LBW birth, smoking, substance abuse, prior birth <24 months, and are younger in age than either the S Women or the Non-Citizens. They also have higher rates of medical risks than the Non-Citizens. An additional maternal risk factor is being an African American woman.

MATERNAL RISK FACTORS, 2005

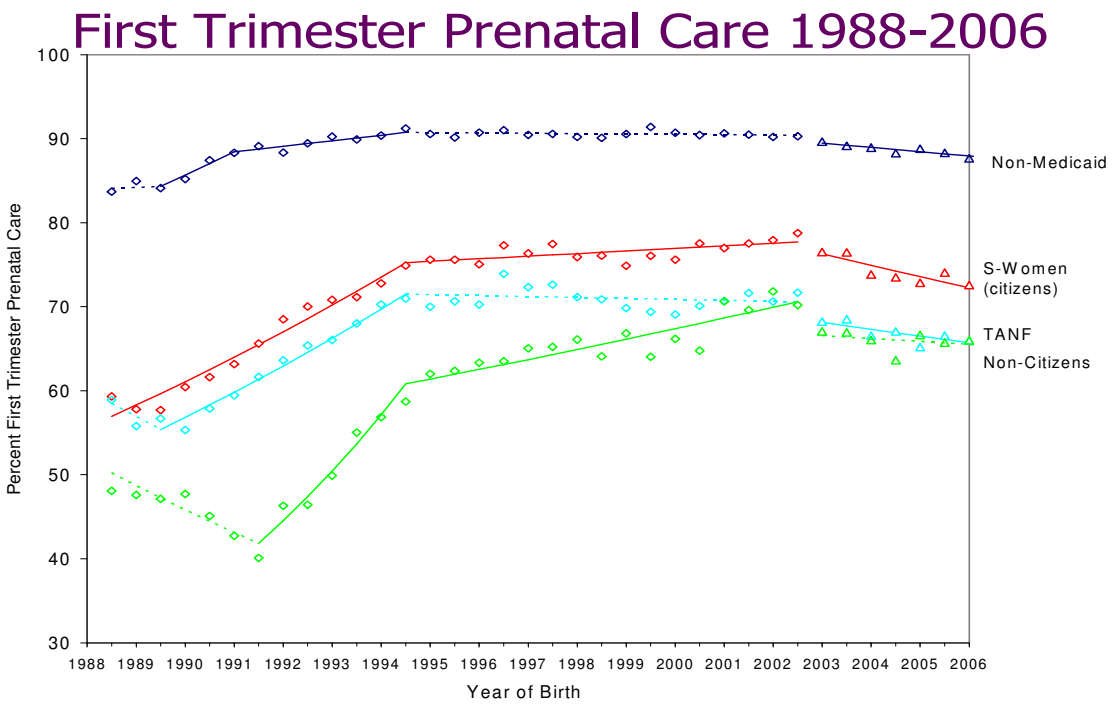
	Non-Citizens	S-Women	TANF
Prior LBW Birth	2.6%	3.6%	5.2%
Medical Risks (HPTN & DM)	10.1%	11.5%	10.6%
African American	2.0%	3.7%	9.1%
Smoking	0.4%	14.1%	30.3%
Substance Abuse	0.4%	2.8%	12.2%
Primiparous (First Time Mothers)	32.2%	41.1%	31.4%
Prior Birth <24 mos (for those with prior births)	21.1%	26.3%	31.6%
Average Age (yrs)	26.5	25.7	24.3
RISK LEVEL	LOW	MEDIUM	HIGH

Cawthon, Laurie. "Reaching High-Risk Pregnant Women." FS Regional Presentation 11/2007

Data from 2006 (See table in County Profiles, page 7, Table 1) demonstrate that TANF women tend to have the highest prevalence of maternal risk factors and subsequently the highest rate of poor birth outcomes. They have the highest rates of low birth weight, preterm births, and infant mortality among all women.

2. Decline in Access to First Trimester Prenatal Care

First steps data clearly demonstrates that since 2002 access to prenatal care in Washington has declined, reflected both by decreases in first trimester prenatal care entry and increases in late or no prenatal care. Since 2003, first trimester prenatal care has decreased for all Medicaid women, with statistically significant decreases for TANF women and S women. See following graph. In addition, all three subgroups of Medicaid women are entering prenatal care later than Non-Medicaid women.



Cawthon, Laurie. "Prenatal Care Access in Washington: Is there a Crisis?" FS Regional Presentation 11/2007

How did we proceed?

Convened stakeholder meetings - Data presentations about these two problems were presented to over 450 MSS/ICM provider staff and administrators at five regional meetings across the state in November and December 2007. Analysis by DSHS RDA staff categorized and quantified data collected during breakout sessions.

Additional community stakeholder meetings in selected communities with the lowest rates of entry into first trimester care have also informed this process.

Review of Literature by MSS clinical team - The purpose of the literature review was to recommend a program definition of high risk, identify evidence based risks associated with poor birth outcomes and research evidence based interventions to address the risks. Appendix B provides a condensed reference list of the most pertinent articles arranged by topic area. A full bibliography of the literature review is available upon request.

Examined other state models – The clinical team reviewed MCH/Medicaid Programs in all 50 states by looking at their overall program models, goals, target population and funding mechanisms. The list was cut to 22 states for further review of their evidence based risking and interventions to improve birth outcomes.

Additional information was collected through interviews with many state programs to identify the following:

- Use of evidence based risking and intervention
- Reimbursement models
- Model of service delivery
- Outcomes achieved

Michigan, Colorado and Florida were identified as states with components that are most aligned with our program goals and offer promising practice screening tools and interventions that could be adapted for MSS.

What did we learn?

Stakeholder Meetings Findings

At the First Steps regional meetings input was solicited from provider staff that work directly with clients. We learned that the experience of providers validates the data presented.

When asked to identify and discuss barriers clients experience in their communities, those commented on most frequently were:

- Lack of prenatal providers
- Providers require medical coupon before they will serve clients
- Lack of understanding /education by the population at large, about the value/importance of early prenatal care
- Transportation
- Clients overwhelmed by current life circumstances

When asked to offer solutions to improve access, those recommended most often were:

- Outreach/marketing (Media, community groups, providers)
- Increase Care Coordination/Case Management
- Client incentives
- Simplified access
- Reduce program documentation requirements and number of risk factor
- Reimbursement - allow fiscal flexibility, let agencies decide when to use more resources for higher risk; do not limit units, reimburse for care coordination/outreach/groups

A full 39 page report of all stakeholder comments can be found at: http://fortress.wa.gov/dshs/maa/firststeps.

Literature Review Findings

When reviewing the literature for risks associated with pregnancy, preterm birth was consistently identified as a major public health problem because it is associated with 75% of causes for

perinatal morbidity and mortality for infants born without congenital abnormalities (High-Risk Pregnancy, ACOG – 2007).

The Institute of Medicine (IOM) 2007 Preterm Birth Report offers a critical review of the most current research on preterm birth and effectiveness of interventions to reduce risk. The IOM report clearly states that there is no known risk condition to predict preterm births. The cause(s) of preterm birth is not clearly understood and it is likely multifactorial. However, the report identified three components of care, that when consistently applied, may confer some protection against preterm birth:

- Continuing risk assessment
- Health promotion, defined as improving preconception, interconception, and pregnancy health education, in addition, treating infections and avoiding teratogens
- Interventions to modify medical and psychological risk

The cause(s) of preterm birth are not well understood but identifying women at risk for preterm birth and providing increased intervention and care coordination has the potential of positively affecting birth outcomes for these women. Although risk factors were defined in slightly different ways in various programs and in the literature, there is a common thread in all the research and examples explored. Risks fall into several key domains and can be broken out in a variety of ways depending in a program's focus and capacity.

The team then compared the current MSS risk factors to the risk factors most associated with poor birth outcomes identified in the literature (i.e. from the IOM report, March of Dimes and CDC, etc.), in three other state models (CO, FL, MI), and from an analysis of First Steps data. The results of this comparison and the preliminary recommendation of which risk factors the program should refocus on are summarized in Appendix C.

Other State Models Findings

The components of other state models were compared to each other and to the literature.

Highlights of the findings are below:

- Focus on program outreach
- Use standardized screening tools to target high risk women
- Support examining alternative funding mechanisms
    - Contracted reimbursement is used for packages of service delivery, and may have performance measures and data collection elements attached to reimbursement.
    - Several simultaneous service delivery models are funded at one time based on local needs
    - Community collaboration is funded
    - Reimburse for activity verses visit, amount determined by risk
- Maintain a client registry/tracking system and collect outcomes key to program implementation and evaluation.
- Use standardized documentation and screening tools across programs
- Health education and risk assessment with appropriate follow-up intervention
- Care Coordination

A complete summary of data collected about other state models can be found in Appendix D.

Contributors to the Problems

Reasons for recent declines in first trimester prenatal care entry include OB provider issues, client issues and systems issues. Data from surveys, commentary recorded from community stakeholder meetings, and information provided by MSS Providers have helped identify statewide barriers, as well as specific local barriers women are encountering. The problem is complex.

Perceptions about what may be contributing to the problems have been documented through PRAMS data, MSS/ICM Provider stakeholder input, community stakeholder meetings, and other methods. The chart in Appendix E represents a sample of those perceptions.

Maternity Support Services will continue to engage in specific activities that address this problem, but significant improvement will require implementation of collaborative strategies between multiple systems, programs and agencies that address OB provider, client and systems issues. The recommendations described in this paper for reaching the highest risk women for poor birth outcomes will undoubtedly have an impact on improving entry into first trimester prenatal care.

What do we recommend?

Synthesizing the data collected from all sources the team recommends that to reach the women of highest risk for poor birth outcomes a comprehensive approach must be adopted due to the complexity and interrelatedness of the problems and potential solutions. It is important to note that the literature does not provide a guarantee of improved outcomes if certain interventions are implemented. However, the literature does recommend certain components of programs which should be included to increase the probability of better birth outcomes. MSS/ICM providers also provided many valuable suggestions the First Steps program will consider implementing.

Use of Framework for Delivering MSS to Women at High Risk for Poor Birth Outcomes

The framework for identifying and engaging high risk women translates into the following for MSS:

- **Health Promotion Activities:** To increase public knowledge about the importance of early prenatal care and educate medical providers on the benefits of MSS.
- **Increased Outreach:** To identify and engage clients into prenatal care and MSS early in their pregnancies and engage medical providers to increase care coordination.

- **Tailor MSS:** To provide brief initial screening, referral, and intervention based on identified risks, and periodic assessment to adjust interventions based on acuity level.
- **Promote Care Coordination/Case Management:** To integrate client services provided by multiple systems, including the health care community, to promote continuity of coordinated, risk-appropriate care and services.
- **Address Systems Issues:** To reduce barriers at the state and local level.

At the inception of the First Steps Program the components of the above framework were all implemented concurrently. The capacity to continue to prioritize these activities has diminished over time and continues to vary by community due to available resources and political will.

A logic model portraying the outcomes and impact of supporting this framework can be found in Appendix F. Specific activities that could be implemented and evaluated are listed under specific framework component headings and can be found in Appendix G.

Implementation of Specific Projects

Continuing, recently launched, and proposed projects that will support the framework implemented by MSS state staff currently include:

- First Steps team continues to convene, facilitate and participate in work groups with DSHS and providers to collaborate and resolve barriers to clients receiving services
- First Steps media campaign utilizing social marketing techniques to target messages
- First Steps supports community stakeholder meetings focused on first trimester entry into prenatal care

Future projects that support additional components of the framework will be launched in stages over time.

Development of a Pilot

MSS develops a pilot, with an evaluation component, to identify activities and processes that support the framework and prove effective to include:

- Use of a standardized screening tool
- Risk factor refinement
- Interventions based on risk factor acuity levels
- Exploration of reimbursement models, cost containment, budgetary constraints

What we need today

- Management approval to pursue development of a pilot
- Agreement on a collaborative approach to addressing prenatal care issues, possibly a follow-up meeting to discuss prenatal care findings and strategies.